Dissonance between religion and psychiatry is not new. There currently exists a form of entente cordiale between the two, although there are those who find them incompatible. Collaboration between the important areas of religion and psychiatry can be viewed as a desirable goal which nurtures the whole person, promotes an integrated purpose, and enhances an experience of faith that is meaningful and responsible.

One author's involvement in teaching a required course in psychiatric/mental health nursing in a church-related (Mennonite) college has led to a number of observations of how nursing students experience this dissonance. It is primarily a conflict of the students' faith values and beliefs and how these may not "fit" what they perceive about mental health principles that are taught. In part, it emerges from a rather narrow understanding of the mental health/mental illness continuum. In addition, there may be dissonance related to their attribution of illness and/or outcomes to God or of their perception of religiosity as a psychiatric symptom in clients. It may also be difficult to acknowledge that religion has sometimes hurt rather than helped clients who are hospitalized. Dissonance exists when the students' values are challenged or threatened, causing psychological discomfort and tension.

Conceptual Framework
In his book, A Theory of Cognitive Dissonance, Festinger pioneered this concept (Festinger, 1957). He states that dissonant relations often exist among cognitions giving rise to pressures to reduce and avoid increases in the "non-fitting" relations. Manifestation of the operation of these pressures include behavior changes, changes of cognitions, and circumspect exposure to new information and opinions. The magnitude of the dissonance will be a direct function of the importance of the two elements in conflict.

Religious beliefs are often important to the nursing student, as is the required course in psychiatric/mental health nursing. The effectiveness of efforts to reduce the dissonance will depend on the resistance of the student to changing the cognitive elements at the base of the conflict. It will also depend on the availability of new information and on significant persons who supply these new elements that may not be consonant with existing cognitions. Childhood beliefs tend to be questioned in the process of maturing and either rejected or accepted in light of the new information (Panzarella, 1974).

Some students successfully integrate their values of religion and

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mental health principles and see a positive collaboration between the two. Others experience little dissonance when religious values are relatively unimportant or are seen as consonant with mental health principles. Still others may see the two as irrelevant in relationship to one another. Finally, some will perceive religious values and beliefs as conflicting with the principles and practice of psychiatric care. Of very special concern is that increased dissonance and subsequent anxiety frequently result in misinterpretation or misperception of new information and will thus result in a poor learning experience.

Original Study

The purpose of the original study completed in 1978 was to develop an instrument to assess cognitive dissonance in nursing students with strong religious backgrounds who are required to study psychiatric/mental health nursing. Special attention could then be given to students whose scores indicated their dissonance might hinder them from a positive learning experience. It was also used to examine the effect of the course by looking at their scores before and on completion of the class. We assumed that if their score was lowered during this time, their dissonance was managed in such a way as to allow learning to take place.

The Religious and Mental Health Inventory (RMHI) was developed by one of the authors using positive and negative statements with a five point, Likert-type response column. Exam-

ples of items on the survey are:

1. True Christians do not become mentally ill.  SA A N D SD
2. Increased knowledge tends to diminish one's religious beliefs.  SA A N D SD
3. Mental illness is a punishment for sin.  SA A N D SD

The test-retest method was used to establish a reliability estimate of .71. Validity was established through prediction of scores obtained by known groups. A two-tailed t-test was computed and was significant at the .01 level.

The purpose of this study is to analyze the data compiled from administering the RMHI to nursing students at the same church college over a 6-year period. We were particularly interested in several aspects of this data. First, has the RMHI continued to be an effective indicator of dissonance in students? Further, has the course design and development consistently helped nursing students with strong religious values to deal constructively with their dissonance in the clinical setting? Second, we analyzed the relationship of several sociological variables (age, sex, and religious affiliation) to the scores on the RMHI. Finally, for broader use, we were interested in detecting whether responses to items on the RMHI followed any underlying attitudinal patterns, and what social or religious attitudes they suggest.

Method and Results

Over the 6-year period we collected data from 203 nursing students. Their mean age was 24.49 years, with 50% of them being 21 years or younger. Ninety-one percent of this group were female. There were 114 (56%) from the supporting church's (Mennonite) constituency, while 89 (44%) were otherwise affiliated.

Each student took the RMHI twice, once before the 8-week clinical course and once after. The mean score of all the students over the 6-year period before the course was 140 and 123 after. The t-test comparing these course scores was significant at the .01 level. The RMHI is designed so that the higher the score, the more potential exists for cognitive dissonance. Thus, for the 6-year period scores were reduced an average of 17 points, indicating a change in the direction of a reduction of dissonance and supporting the idea that new information was accepted and integrated. There was no significant comparative difference in the scoring among any of the years. This suggests that over time the RMHI has measured potential cognitive dissonance consistently.

The relationship of age, sex, and religious affiliation was tested through the Pearson correlation, comparing each of these variables with the score on the first RMHI taken by each student. There was no significant relationship between the scores and the sex of the student or the various religious affiliations. There was a negative relationship (r = −.1483, p = .05) between age and test scores. Specifically, the older the student, the lower the score on the RMHI.

Finally, we were interested in discovering any underlying patterns and attitudes emerging from the RMHI responses. This was accomplished through use of the Guttman scaling. This type of scaling is set up to be unidimensional, cumulative, and orders the items according to difficulty. Thus, a person who responds positively to a difficult question should also agree with other questions as they become less difficult. The result is to establish a pattern of social attitudes: what are the most difficult items to agree with, what are the least difficult, and how are they conceptually ordered? One scale was of particular interest and is built on the following items, ascending from the most difficult (reproducibility .9627; scalability .7532):

1. Mental illness is a punishment for sin.
2. True Christians do not become mentally ill.
3. Mental illness may be the...
4. A mentally ill Christian can be healed through strengthened belief in God.
5. Mental illness can be overcome by faith and prayer.

While the scale embarks both explanations for illness and remedies for healing, overall it points toward a perception of where "responsibility" lies in relationship to mental health/illness. A central component in the faith of many believers is a God who acts in human affairs. From the believer's viewpoint, the outcomes of events will often be interpreted from the perspective of divine causation. General attribution theory proves useful as a theoretical perspective for explaining attribution to divine intervention, given its emphasis on how people make inferences about the cause of events. Gorsuch and Smith (1983) found by using attribution theory that highly religious persons attribute more responsibility to God for extreme rather than mild outcomes.

The above scale seems to suggest that students from strong religious backgrounds do not attribute the cause of mental illness to God, but do consider divine intervention to be part of the healing process. The underlying attitude suggests that while the cause of mental illness is not God-inflicted, responsibility for remedy is partially rooted in a God-related dimension. This fits the pattern that more religious persons are likely to attribute responsibility for outcomes, in this case healing mental illness, to God.

On a practical level, persons who readily agree with the more difficult items on this scale (a scale-type 1, 2, or 3) are likely to experience acute cognitive dissonance in a psychiatric clinical setting. They would likely attribute high responsibility to God for the healing process and would tend to see a commonly accepted psychiatric approach to healing as less important. This is significant for nurses as they work with clients as well as students. It is crucial in assisting students in their general assessment to also include a careful assessment of the client's spiritual needs and plan their care with this in mind.

Conclusion
Several conclusions can be drawn from this study. First, cognitive dissonance occurs when there are "nonfitting" relations among cognitive elements including opinions, beliefs, values, and attitudes. Nursing students from strong religious backgrounds may experience this in the area of psychiatry and their faith values. The data support that psychiatric mental health nursing can be taught and experienced in a challenging, yet supportive manner, assisting highly religious students successfully to manage their dissonance. This can be done without diminishing personal faith and can result in a broader understanding of the value of the collaboration of faith and psychiatry.

Further research could be strengthened by using control groups of persons who take the RMHI simultaneously with the nursing students, but who do not have the course and clinical experience. Such research is currently being done.

Second, the results indicate that older students have less dissonance than the younger group. Older students are likely to perceive the learning experience as less threatening and may even welcome new insights into their own and their family relationships. In contrast, this may be one of the first occasions when younger students have had their beliefs challenged. They may also be confronted with very religious persons who are dysfunctional and for whom the student's preconceived "answers" do not seem to work.

Finally, preliminary results indicate that for students from strong religious backgrounds, important conceptualization and attitudinal patterns may emerge around the question of where responsibility lies for the healing process. These patterns may increase their cognitive dissonance as they experience the clinical component of the psychiatric/mental health nursing course. This is equally important for nurse clinicians to recognize as they work with clients from strong religious backgrounds.

References

Cognitive Dissonance
KEY POINTS


1. The dissonance that has traditionally existed between religion and psychiatry may become focused for students from strong religious backgrounds as they meet the requirements of psychiatric/mental health nursing.

2. General attribution theory is useful in explaining that highly religious persons attribute more responsibility to God for extreme rather than mild outcomes. Highly religious students are not likely to attribute the cause of mental illness to God, but do consider divine intervention to be part of the healing process.

3. It is possible to teach psychiatric/mental health nursing in a challenging and supporting manner without diminishing personal faith.